Naturopathic Physician License Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

(This page intentionally left blank.)

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct forms required.

☐ **Application Fee.** This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: Legal name is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year when you were born.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

☐ **4. Education:**
List all of your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

☐ **5. Experience:**
List all of your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

☐ **6. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **7. Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

Additional Information

Education:

To qualify for license as a naturopathic physician in Washington State, you must have graduated from a naturopathic school approved by the Board of Naturopathy. The following schools have been approved:

- *Bastyr University, Kenmore, Washington
- National College of Naturopathic Medicine, Portland, Oregon
- Southwest College of Naturopathic Medicine and Health Sciences, Tempe, Arizona
- University of Bridgeport College of Naturopathic Medicine, Bridgeport, Connecticut
- *Canadian College of Naturopathic Medicine, Toronto, Ontario

*Provisionally approved

Exams:

An applicant must pass each of the following examinations with a score of 75 before license will be granted:

1. **Naturopathic Physicians Licensing Examinations (NPLEX):**

   Part I Basic Science Examination

   Part II Clinical Science Examination

   Minor Surgery Add-On Examination

2. **Washington State—Jurisprudence Examination**.

Submit the following:

a. Official transcripts sent directly from the college where the naturopathic degree was obtained.

b. Verification of passing the NPLEX basic science examinations, clinical science examinations and add-on examinations of minor surgery sent directly from NPLEX.

c. Verification letters sent directly from **all states** where you have ever obtained a credential to practice in a health care field.

d. Completed Washington State Jurisprudence examination.

Please note: All NPLEX Basic and Clinical Science examinations are required for Washington State Naturopathy license including the minor surgery add-on. Examinations that do not meet Washington State reexamination specifications, as stated in **WAC 246-836-050**, will not be accepted.

(This page intentionally left blank.)

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0252050000

Naturopathic Physician License Application

Please type or print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s): _____

Will documents be received in another name? ☐ Yes ☐ No If yes, list name(s): _____

For Office Use Only

License #_____ Date Issued _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

State/Jurisdiction	Profession	License Type	License		Method of License	Currently in Force	
			Year Issued	Number		Yes	No
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

☐ Yes ☐ No I have never been licensed to practice naturopathy in any jurisdiction.

4. Education

List all of your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Full Name, City and State of Schools Attended	Degree Earned	Attendance	
		Start Date	End Date

5. Experience

List all of your professional experience. Exclude activities listed under other sections. Attach additional completed pages if you need more space.

Name and location of institution	From (MO/DAY/YR)	To (MO/DAY/YR)	Type of experience or specialty

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ _____ in
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

(This page intentionally left blank.)

Washington State Department of Health
Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Intravenous Therapy Attestation Authorization

I attest and affirm I have completed sixteen hours of graduate level training, at least eight hours of

graduate level instruction at: _____

_____

Name and address of institution. Please print clearly.
Must be a school approved under chapter 18.36a, 18.71, 18.57, OR 19.79 RCW _____

_____

_____

The training/instruction, titled _____, included indications, contraindications, formularies, emergency protocols, osmolarity calculation, aseptic technique, and proper documentation.

I further affirm, in accordance with **WAC 246-836-220**, I will retain training documentation for at least five years from the date of this attestation. I understand failure to give this documentation upon request may result in disciplinary action against my license.

Print Practitioner's name _____

Practitioner's signature _____ Date _____

License Number: _____

Address: _____

_____

For office only:

☐ Approved ☐ Disapproved _____Review Date _____

Signature _____

(This page intentionally left blank.)

Washington State Department of Health
Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Controlled Substances, Limited to Codeine and Testosterone Products Authorization

I attest and affirm that I have completed at least four hours of graduate level instruction at: _____

_____

Name and address of institution. Please print clearly.
Must be a school approved under chapter 18.36a, 18.71, 18.57, OR 19.79 RCW) _____

_____

_____

The instruction, titled _____ , included principles of medication selection; patient selection and therapeutics education; problem identification and assessment; knowledge of interactions, if any; evaluation of outcome; recognition and management of complications and untoward reactions; and education in pain management and drug seeking behaviors.

I further affirm that, in accordance with **WAC 246-836-211**, I will retain training documentation for at least five years from the date of this attestation. I understand failure to give this documentation upon request may result in disciplinary action against my license.

Print Practitioner's name _____

Practitioner's signature _____ Date _____

License Number: _____

Address: _____

_____

For office only:

☐ Approved ☐ Disapproved _____ Review Date _____

Signature _____

(This page intentionally left blank.)

Washington State Department of Health
Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Candidate Name: _____

Date: _____

State of Washington
Health Systems Quality Assurance Division

Examination validated, edited and approved by Washington State

Jurisprudence

Naturopathic Physician Program Licensing Examination

Instructions:

The Jurisprudence examination is an “open” Naturopathic Physician law book examination.

Never mark more than one answer to a question. There is only one best answer. If you think that two answers are equally correct, choose and mark only one of them. Comments concerning this may be placed on the Test Feedback Form attached at the end of the examination.

To change an answer, erase completely and then mark another choice.

True or False

1. Naturopathic physicians can take and interpret standard radiographs:

   A. True
   B. False

2. The naturopathic scope of practice in Washington State includes hypnosis, biofeedback, and counseling:

   A. True
   B. False

3. Naturopathic physicians have prescription rights to include some controlled substances:

   A. True
   B. False

4. Naturopathic physicians may use “physical modalities” to include physical, chemical, electrical, and other noninvasive modalities:

   A. True
   B. False

5. A person may represent him/herself as a naturopathic physician in Washington State after graduation from an approved school, and prior to being issued a license to practice, only if the services provided are billed by a licensed practitioner:

   A. True
   B. False

6. Common diagnostic procedures include those that require a superficial surgical incision:

   A. True
   B. False

7. A naturopathic physician may prescribe and fit a diaphragm contraceptive device:

   A. True
   B. False

8. If your patient is confused and thinks you are a medical doctor, you need not explain the difference in scope of practice unless the patient requires something that you cannot provide:

   A. True
   B. False

True or False

9. A Washington State license allows you to practice in any state as long as you maintain a current license in Washington State:

    A. True
    B. False

10. Minor office procedures include repair of superficial abrasions and lacerations:

    A. True
    B. False

11. Naturopathic physicians can perform and interpret any radiographic studies:

    A. True
    B. False

12. Homeopathy is part of the scope of practice of naturopathic medicine in Washington State:

    A. True
    B. False

13. Manual manipulation includes both the spine and extremities and can be done by hand or mechanical means:

    A. True
    B. False

14. Naturopathic physicians may perform endoscopy:

    A. True
    B. False

15. Once licensed, a naturopath may delegate any and all procedures over to an unsupervised person as long as that person is located in the same office.

    A. True
    B. False

16. Naturopathic physicians are prohibited from providing treatment of malignancies except in concert with an MD or DO.

    A. True
    B. False

Multiple Choice

1. The disciplinary authority finds that a naturopathic physician can no longer practice safely due to a health condition. The **primary** responsibility of the disciplinary authority is to:

   A. Protect the public.
   B. Decide on appropriate punitive action.
   C. Provide for the naturopathic physician's rehabilitation.
   D. Maintain the integrity of the profession.

2. Failure to comply with a subpoena or notice issued by the disciplinary authority is considered:

   A. A misdemeanor.
   B. A gross misdemeanor.
   C. Unprofessional conduct.
   D. Misrepresentation or fraud.

3. The cost of a voluntary substance abuse monitoring program is the responsibility of the:

   A. License holder.
   B. Disciplinary authority.
   C. License holder's employer.
   D. License holder's insurance carrier.

4. Dishonest or unethical treatment of patients is deemed unprofessional conduct:

   A. Depending on the license holder's intent.
   B. Whether or not a crime has been committed.
   C. Only after harm or injury to patients has been demonstrated.
   D. Only after criminal behavior has been established in a court of law.

5. Applicants for license must reveal:

   A. All material of facts.
   B. Only prior convictions.
   C. Only violations of professional misconduct.
   D. All information two years prior to application.

6. An applicant passes a Washington State professional licensing examination, but fails to disclose that license was suspended in another state. The disciplinary authority will most likely:

   A. Require that the examination be retaken.
   B. Issue sanctions against the applicant.
   C. Require that the applicant explain matters.
   D. Take action only after obtaining all the records from the other state.

Multiple Choice

7. Prescribing controlled substances for one's own use is:

    A. Regulated.
    B. Permitted.
    C. Prohibited.
    D. Allowable under certain conditions.

8. When the disciplinary authority requests information regarding a complaint, the license holder must:

    A. Respond in person.
    B. Obtain legal counsel.
    C. Respond within 5 working days.
    D. Furnish in writing a complete explanation.

9. Which of the following constitutes misrepresentation or fraud:

    A. Advertising free services.
    B. Giving out coupons for reduced fees.
    C. Waiving co-payments to the patient and insurance company.
    D. Failing to disclose discounts or reduced fees on a patient's bill.

10. A health care professional suffering from a contagious disease must:

    A. Refrain from patient contact until recovered.
    B. Notify the disciplinary authority immediately.
    C. Protect patients by wearing protective clothing.
    D. Promptly disinfect the office area and all clothing.

11. A health care professional agrees to a patient's request for treatment using an untested, experimental method. The professional fails to disclose this information when it is requested by the disciplinary authority. This is an example of:

    A. A research procedure.
    B. Unprofessional conduct.
    C. Investigational procedures.
    D. Practitioner-patient privilege.

12. A health care professional may engage in sexual activity with a current adult patient:

    A. Under no circumstances.
    B. If the patient consents, and is not coerced in any way.
    C. If such contact does not abuse the practitioner-patient relationship.
    D. If such contact will not adversely affect the patient or other individuals.

Multiple Choice

13. Your friend, another practitioner, is attracted to a new patient and would like to pursue a relationship. Which action should your friend take to best avoid misconduct?

    A. Weigh all the pros and cons before doing anything.
    B. Ignore any feelings and continue to treat this patient.
    C. Refer this patient to another practitioner for treatment.
    D. Determine the patient's feeling by having a phone conversation.

14. An individual who in good faith files a complaint against a naturopathic physician charging unprofessional conduct is:

    A. Immune from any civil or criminal action suit related to the complaint.
    B. Required to appear in person at every hearing related to the complaint.
    C. Entitled to the full refund of any payment for naturopathy services rendered.
    D. Entitled to compensation in the amount of the designated civil penalties.

15. A naturopathic physician discloses health care information about a patient for a research project, without patient authorization. This project has been approved by institutional review. According to the law, this action is:

    A. Unethical.
    B. Permissible.
    C. Unprofessional conduct.
    D. Allowable only if the patient is notified.

16. Which of the following is required for license renewal each year?

    A. 10 hours of continuing education courses in any health related education.
    B. 15 hours of continuing education courses only in diagnosis as listed in RCW 18.36A.040.
    C. 20 hours of continuing education courses only in diagnosis and therapeutics as listed in RCW 18.36A.040.
    D. 30 hours of continuing education courses only in therapeutics as listed in RCW 18.36A.040.

17. The main intent of the Uniform Disciplinary Act is to provide:

    A. Higher standards for health care providers.
    B. Increased accountability in the health care professions.
    C. Incentives for state health care professionals to meet federal guidelines.
    D. Standard procedures for licensing health care professions and enforcement of laws and regulations.

Multiple Choice

18. Which of the following may naturopathic physicians order:

    A. PA and lateral chest X-ray.
    B. Pelvic Ultrasound.
    C. Abdominal CT scan.
    D. All of the above.

19. Naturopathic physicians may use and prescribe which of the following:

    A. Immunizations.
    B. All legend drugs.
    C. Prescription vitamins.
    D. All of the above.

20. It is permissible for licensed naturopathic physicians to:

    A. Become sexually involved with patients.
    B. Prescribe controlled substances for their own use.
    C. Practice after full recovery from the misuse of alcohol.
    D. Accept a valuable gift from a potential supplier of naturopathic products.

21. A licensed naturopathic physician must keep documents supporting education and training in controlled substances for:

    A. One year.
    B. Five years.
    C. Ten years.
    D. Indefinitely.

Washington State Department of Health
Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Test Feedback Form

Profession: **Naturopathic Physician**

Exam Section: **Washington State Written Jurisprudence Examination**

The purpose of this form is to give you the opportunity to provide feedback about this examination. Please tell us which question number you are commenting about. Be specific. All comments will be reviewed and considered by the examination staff and the Naturopathic Physician Credentialing staff.

Do not include your name on this form.

We thank you for any suggestions that improve the services we provide you.

Return this form separately to Naturopathic Physician Credentialing at the address above.

Washington State Department of Health
Naturopathic Physician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

This form must be completed by **every** state Naturopathic Physician credentialing agency you were licensed by. The agency must return this form directly to the Department at the address listed above.

Part 1—Note To Applicant

Complete Part 1. Submit form(s) to all state naturopathy programs where you have been licensed, certified or registered.

Name: _____

I was licensed by the _____ Board/Committee of the Naturopathic Physician

Credentialing agency _____

Under the name _____

My original license number is _____

My address is _____

Applicant's Signature _____

Part 2

To be completed by **every** state Naturopathic Physician credentialing agency you were licensed by. The agency must return this form directly to the above address.

License issued on _____ License Number _____

Applicant licensed by: ☐ Exam (if yes, name and date of exam)
☐ Endorsement
☐ Waiver

Is applicant currently licensed in this state? ☐ Yes ☐ No Date of expiration: _____

If not currently licensed, when did license expire? _____

Is the applicant in good standing? ☐ Yes ☐ No If no, please attach detailed explanation. _____

_____

_____

_____

Has the license ever been encumbered in any way? ☐ Yes ☐ No (Revoked, suspended, surrendered, restricted, placed on probationary status or under investigation) If yes, please attach detailed explanation.

_____

_____

_____

_____

Is any action pending against applicant? ☐ Yes ☐ No If yes, please attach detailed explanation.

_____

_____

_____

_____

Print Name: _____ Title: _____

Signature: _____ Date: _____

State: _____

State Seal

RCW/WAC Links and Online Web Sites

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

On-Line

AIDS Training Resources ..... Reference Page

Naturopathic Physician ..... Web Page